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Employer Services Advisory

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Tips and Guidelines For Establishing An External Claims And Appeals Process

This is the fourteenth in a series of alerts intended to help guide employers and plan sponsors through their new obligations under the recently-enacted health care reform laws and related guidance.

The health care reform laws require non-grandfathered plans to implement an external appeals process and adopt new external appeals procedures. While the Department of Labor and Internal Revenue Service have indicated that they will not enforce these requirements before July 1, 2011, the effective date for these modifications is the first day of the plan year beginning on or after September 23, 2010 (which was January 1, 2011 for calendar year plans).

The following are several tips and guidelines that plan sponsors should consider when revising their external claims and appeals process for these new requirements. (Note that tips and guidelines for revising internal claims and appeals process were provided in our **prior alert**.)

Plan sponsors of fully-insured plans should confirm that the insurer will meet the new requirements for external claims procedures by the deadline. If the policy year for your insurance is different than the plan year, you should determine what date the new requirements will apply and coordinate the compliance date with your insurer.

Plan sponsors of self-insured plans should consider the following tips and guidelines when establishing their own external appeals process and procedures to comply with these new requirements:

- If external appeals are initially received in-house, consider feasibility, delegation, and contingent processes when employees who are responsible for receiving and processing the appeals are absent.
- If a claims administrator is involved in the external claims process:
    - coordinate the review process with the claims administrator;

    - review the service agreement with the claims administrator to identify any amendments needed;
    - evaluate the allocation of risk and liability between the plan and claims administrator;
    - ensure your plan language clearly and sufficiently delegates appeal authority to the claims administrator as a fiduciary; and
    - ensure a current business associate agreement exists with the claims administrator.
- Determine whether to comply with an existing state external review process (if permitted) or follow the federal guidelines for external review. (If you also offer fully-insured coverages you may wish to follow the state external review process, if permissible, to maintain a consistent process among both fully-insured and self-insured benefit options.)
- If you are following the federal guidelines, identify at least three (3) Independent Review Organizations (IROs) with which to contract. Note:
    - The third-party administrator may do this on your behalf, but you are still deemed to have a direct contract with the IRO and you have a duty to research and monitor the IRO to ensure the IRO is not biased;
    - Business associate agreements must be executed by the plan sponsor and the IROs (this is in addition to any business associate agreement between the claims administrator and IRO); and
    - Ensure the contract with the IRO meets all requirements under health care reform.
- If you are following state guidelines, determine requirements to contract with IROs.
- Implement or coordinate with your claims administrator a process to determine within five business days whether a claimant's request is eligible for external review, and to notify the claimant within one business day after completing the review.
- Implement or coordinate with your claims administrator a process for expedited external review to immediately determine whether a claimant's request is eligible for external review and assign it to an IRO.
- Design or review notices of an external claim decision to include (a model notice is available):
    - denial code and meaning;
    - the plan's standards used to make the determination;
    - date of service;
    - health care provider;
    - claim amount;
    - diagnosis code and meaning;
    - treatment code and meaning; and
    - contact information for the HHS Office of Consumer Assistance.
- Determine if the plan covers a significant number of participants who primarily speak the same non-English language. If so, translate the notice into that non-English language.
- Confirm that your employees, the claims administrator's or IRO's employees, and any other individuals involved in the claims process do not receive compensation or other rewards based their denial of benefits or similar factors.

- Do not stop benefits for the claimant while his/her claim is being reviewed.
- Revise your plan documents/summary plan descriptions to include the external claims process.
- Review forms used for explanations of benefits and other notices and revise these to incorporate an explanation of the external claims and appeals process.

The above list of tips and guidelines is intended as a practical tool for plan sponsors and not an exhaustive list of all the requirements of the new external claims procedures under health care reform laws. If you have any questions about the new external claims procedures, please contact one of the members of MLA's Employee Benefits & Executive Compensation Group.

With a team of attorneys who are highly experienced in the employee benefits field, MLA can provide answers to questions and assistance in complying with health care reform laws and related guidance.